4-H Healthy Living Logic Model – Prevention of ATOD (Alcohol, Tobacco and Other Drugs)

SITUATION

According to the Institutes of Medicine/National Research Council, for both children and adolescents, early drug use predicts later drug use (O'Connel, Boat & Kenneth, 2009). Meaning that the earlier a child or adolescent begins using or abusing substances, the higher the risk that that individual will become dependent on substances. During childhood, risk for substance abuse is high for those who have a difficult temperament, pool self-regulatory skills, are sensation seeking and impulsive, and who do not tend to avoid harm.

As a child grows up, peers are increasingly important to the child. Children and adolescents with more access and availability to alcohol and drugs, either through friends or family members, are more likely to use them (Mayes and Suchman, 2006; Hawkins, Catalano & Miller, 1992; O'Connell, Boat & Kenneth, 2009). Child and adolescent substance use is also affected by social norms such as friends who use, lack of enforcement of laws and rules, and advertising of substances (e.g., alcohol ads at sporting events).

However, parents who form warm, nonconflictual relationships with their children and who provide adequate monitoring and supervision help protect their children from developing substance use problems. (Mayes and Suchman, 2006; Hawkins, Catalano & Miller, 1992; O'Connell, Boat & Kenneth, 2009). Additionally, prevention scientists, including researchers conducting the *Monitoring the Future* longitudinal survey, have determined that a change in attitudes toward use of substances is usually the first step towards an actual change in use. When teens perceive substances to be dangerous to them then they are unlikely to use them (Johnston, O'Malley & Bachman, 2002 as cited in Health Status of Adolescents and Young Adults, pp. 9).

ALCOHOL:

Following sharp declines during the 1980s, the prevalence of alcohol use among adolescents (12-17 year olds) and young adults (ages 18-25) has remained largely unchanged through the 1990s, with the exception of recent increases in binge drinking (Johnson, O'Malley & Bachman, 2002.) Heavy drinking declined from peaks of 13% in 1996 to 8% in 2008 for 8th grade students, from 24% in 2000 to 16% in 2008 for 10th graders, and from 32% in 1998 to 25% in 2008 for 12th grade students. www.childstats.gov

Excessive alcohol use is the third leading cause of preventable death in the US and is a risk factor for many health and societal problems including motor vehicle accidents. People aged 12 to 20 years drink 11% of all alcohol consumed in the US and more than 90% of this alcohol is used in the form of binge drinks (OJJDP; www.udrtc.rg/documents/Drinking_in_America.pdf).

TOBACCO USE

In 2008, 3% of 8th grade students, 6% of 10th graders and 12% of male and 11% of female 12th grade students reported smoking daily. (www.childstats.org). In 2008, 14% of white 12th grade students reported smoking cigarettes daily in the past 30 days, compared with 6% of black and 7% of Hispanic 12th grade students. (www.childstats.gov).

PRESCRIPTION DRUG ABUSE

In 2008, 15.2 million Americans age 12 and older have taken a prescription pain killer, tranquilizer, stimulant, or sedative for nonmedical purposes at least once in the year prior to being surveyed (National Survey on Drug Abuse and Health, 2009). The NIDA-funded 2008 *Monitoring the Future* Study showed that 2.9% of 8th graders, 6.7% of 10th graders, and 9.7% of 12th graders had abused Vicodin and 2.1% of 8th graders, 3.6% of 10th graders, and 4.7% of 12th graders had abused OxyContin for nonmedical purposes at least once in the year prior to being surveyed.

4-H HEALTHY LIVING LOGIC MODEL DETAILS
- *Outcomes appropriate for children ages 5-9 are noted as **(child)***
- *Outcomes appropriate for youth ages 10-19 are noted as **(youth)***
- *Outcomes appropriate for family and community & policy makers are noted as **(family)***

OUTCOMES:
Short – Learning (Knowledge, Attitudes, Skills, Aspirations – KASA)
- (youth) increased perception of risk and refusal skills related to ATOD use
- (youth) improved knowledge, attitudes, skills and aspirations toward ATOD avoidance
- (youth, family) improved understanding and communication of the consequences of substance use, risk-taking, personal responsibility, and the influences of the media targeting adolescent and young adults in advertising and promotion

Mid – Actions (Behavior)
- (youth) increased use of refusal skills when confronted with ATOD use opportunities
- (youth) reduction in use of alcohol, tobacco, and other drugs among 10-17 year olds
- (youth) reduction in proportion of adolescents who drove drunk or rode with a driver who had been drinking alcohol
- (youth) reduction in proportion of adolescents who engaged in binge drinking of alcoholic drinks
  - (parents, families, and community policy makers) engaged in communicating the consequences of access to alcohol and normalizing under-aged dringing and tobacco use
  - (youth) increased positive peer-led messaging related to not using ATOD

Long – Conditions
- (youth) increased age and proportion of adolescents who remain alcohol, tobacco, and drug free
- (child, youth, family) restricted minor's access to tobacco and reduced ATOD use or abuse and reduction in exposure to environmental ("second-hand") tobacco smoke for children
- (youth, family) reduction in unintentional and intentional injuries, including alcohol-related motor vehicle crash deaths and injuries, resulting from alcohol and illicit drug-related use
- (child, youth, family) increased community partnerships or coalitions that conduct comprehensive substance abuse prevention efforts

- (community & policy makers) reduction in minors' access to alcohol and tobacco

OUTPUTS

Who We Target (Audiences)

- Youth (with special focus on new and underserved audiences), families, staff, volunteers, community leaders, partner organizations, and collaborators (example: children of incarcerated parents)

What We Do (Activities)

- Provide tobacco cessation information, resources and support to youth and their families
- Provide multi-component programs targeted to different developmental stages to intervention in ATOD use
- Model non-use among youth with family and friends
- Engage in community mobilization campaigns to prevent and reduce ATOD use
- Design and implement programs with multiple components such as using environmental changes, policy changes, social marketing campaigns, and curricula that meet ATOD prevention standards for skill-building and self-efficacy and involve families in meaningful ways (Adapted from: Society for Nutrition Education, 2009. *State of Nutrition Education & Promotion for Children & Adolescents)*

What We Produce (Tangible Products)

- Cooperative and experiential learning; peer mentoring; family engagement; non-formal educational programs; projects; trainings; workshops; internships and apprenticeships; applied research; evaluations; convened coalitions; grant proposals, developed and awarded; needs assessments; and social marketing campaigns
- Programs that have been disseminated and replicated, curricula and peer-reviewed articles/resources that have been published

INPUTS

- Evidence-based and evidence-informed curricula
- Tradition, prestige, and history of the network of Land Grant and Public Universities
- Human Resources (paid staff, volunteers, instructors, specialists, leaders, and stakeholders)
- Existing 4-H Youth Development and Families curricula, delivery modes, and programs
- National reports and standards (e.g., Healthy People 2020) that establish benchmarks for Healthy Living outcomes
- National partners with interest in supporting Extension's 4-H Healthy Living network
- Published and unpublished research and valid literature focused on healthy behaviors, health promotion, youth development, family development, and community development
- Financial supports such as grants, categorical funding, and fees

- Relationships with national, regional, state, and local health experts, public health networks, and health advocates
- Facilities – local, state, and regional
- Youth leaders and partnerships with networks of young people
- Electronic resources (e.g., eXtension, web conferencing, wikis)
- Cornerstones of a Healthy Lifestyle:
    a. <u>Access</u> – access to safe places and opportunities
    b. <u>Collaboration</u> – effective partnerships across the generations
    c. <u>Science and Research</u> – understanding the science and research behind effective health promotion strategies
    d. <u>Workforce (volunteer and paid)</u> – increasing the capacity of everyone participating in health promotion efforts
    e. <u>Communications</u> – increased awareness and understanding of the value of healthy living through effective, appropriate, and targeted communication
    (Adapted from: Association of State & Territorial Public Health Nutrition Directors, 2006. Retrieved on August 1, 2009; www.movingtothefuture.org)

ASSUMPTIONS/GIVENS

- The contributions 4-H makes to positive youth development through multi-generational, mixed-gender, family-engaged, and non-formal education are valuable to healthy living of all youth.
- Extension is ready to make unique contributions to the health and well-being of young people and their families thanks to its multi-level network, ability to interpret and appropriately apply research findings to improve human quality of life and sustained citizen input and involvement.
- Young people and their families will need to be involved in meaningful learning experiences
- 4-H Healthy Living program development and program implementation will focus on the risks and protective factors that influence the health outcomes of young people.
- Health behaviors are complex and there will continue to be risks and protective factors on which 4-H Healthy Living programs will have little impact.
- Youth will face an increasing amount of choices and opportunities in all facets of their lives; therefore, 4-H Healthy Living programs will evolve with those choices and opportunities.
- Youth and their families can improve their health through increased healthy living knowledge, resources, and by reducing health risk factors.
- Youth and their families have the ability to reach optimal physical, social/emotional health, and well-being.

ENVIRONMENTAL – EXTERNAL FACTORS

- Families will continue to face resource constraints (time, money, transportation, etc.).
- Demands on family time will continue to be a factor in the programs they choose to participate in over time.
- Changes in society and health practices/services/access will impact young people and their families.

- Research will continue to inform the connections between healthy living and positive youth development.
- Obesity prevention and health improvements will continue to be a core mission of USDA/AFRI and state Extension systems.

EVALUTION PLAN COMPONENTS

- Survey, demonstration of refusal skills, and certification
- Trained observer report and rating
- Checklist or portfolio
- KASA (knowledge, attitudes, skills and aspirations/ intentions) data gathered via surveys, focus groups, and interviews
- Health behavior change and health behaviors maintenance data gathered via surveys, focus groups, interviews, case studies, and reports from trained observers
- Learner self-reports focused on outcomes
- Program effectiveness RE-AIM data (www.re-aim.org)
- Process evaluations/accomplishments
- Monitor existing trends, surveillance data, from other studies and networks
- Youth risk surveys, portfolio of activities, and life changes
- Monitor ES237 data
- Review of state Healthy Living plans across regions

RESOURCES

Botvin, G. (2006) "LifeSkills Training" www.lifeskillstraining.com

Johnston, O'Malley, and Bachman, 2002. *Monitoring the Future* as cited in Health Status of Adolescents and Young Adults, pp. 9

America's Children: Key National Indicators of Well-Being (2009) Retrieved August 1, 2009 (www.childstats.gov)

The Community Guide www.thecommunityguide.org/index.html

Mayes, L.C., and Suchman, N. (2006). Developmental pathways to substance abuse. In D. Cicchetti and D. Cohen (Eds.) Developmental Psychopathology, Vol. 3, (pp. 599-619). New York: John Wiley and Sons.

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Glasgow RE, Vogt TM, & Boles SM (1999). *Evaluating the public health impact of health promotion interventions: the RE-AIM framework*. American Journal of Public Health vol. 89(9), p. 1322-1327.

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Healthy People 2010 (include Healthy People 2020 draft objectives) Retrieved on Nov. 6, 2009 www.healthypeople.gov/HP2020/Objectives/TopicAreas.aspx